SUPREME COURT, U.S.
FILED
JAN 30 1995
OFFICE OF THE CLERK

No. 94-972

In The

Supreme Court of the United States

October Term, 1994

TRI-STATE MACHINE, INC.,

Petitioner,

vs.

NATIONWIDE LIFE INSURANCE COMPANY,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

PHILIP F. BROWN
(Counsel of Record)
CHORPENNING, GOOD & MANCUSO CO., LPA
77 East Nationwide Boulevard
Columbus, Ohio 43215-2539
(614) 469-1301
Attorneys for Respondent, Nationwide Life Insurance Company

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

BEST AVAILABLE COPY

QUESTIONS PRESENTED

1. Whether claims brought by a plan sponsor against a plan fiduciary for misadministration, breach of duty, and unfair trade practices, all of which directly implicate the administration of claims for benefits under an employee welfare benefit plan which is governed by ERISA, "relate to" the subject plan and are therefore preempted by ERISA.

2. Whether claims brought by a plan sponsor against a plan fiduciary for misadministration, breach of duty, and unfair trade practices, all of which directly implicate the administration of claims for benefits under an employee welfare benefit plan governed by ERISA, are saved from preemption pursuant to ERISA's "savings clause."

3. Whether, in a case in which a plan sponsor alleges misadministration of benefit claims, breach of duty relating to claims administration and unfair trade practices relating to claims administration, special or important reasons exist to overturn the application of the accepted ERISA preemption analysis in favor of giving an ERISA party state law remedies not allowed under ERISA.

LIST OF PARTIES AND RULE 29.1 LIST OF AFFILIATES

Nationwide Life Insurance Company is a wholly owned subsidiary of Nationwide Corporation. Nationwide Corporation is owned by Nationwide Mutual Insurance Company (95.3%) and Nationwide Mutual Insurance Company (4.7%), both of which are mutual insurance companies.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

LIST OF PARTIES AND RULE 29.1 LIST OF AFFILIATES ii

TABLE OF AUTHORITIES v

STATUTES WHICH THE CASE INVOLVES 1

STATEMENT OF THE CASE 4

The Factual Background 4

The Case Below 7

SUMMARY OF THE ARGUMENT 10

ARGUMENT 12

I. THE CLAIMS MADE BY TRI-STATE IN THIS LITIGATION RELATE TO THE SUBJECT EMPLOYEE WELFARE BENEFIT PLAN, ARE PREEMPTED BY ERISA AND ARE NOT SAVED FROM PREEMPTION 12

A. Tri-State's Claims Clearly "Relate To" The Subject Employee Welfare Benefit Plan 13

B. The State Law Claims Asserted By Tri-State Are Not Saved From Preemption 16

C. The Deemer Clause Is Inapplicable To This Case 18

II. THERE IS NO CONFLICT IN THE CIRCUITS OVER THE APPLICATION OF THE "RELATES TO" DOCTRINE OR THE "SAVINGS CLAUSE" ... 19

TABLE OF CONTENTS – Continued

Page

A. The Circuit Courts Are Not In Conflict Over When A Claim "Relates To" A Plan 20

B. The Circuits Are Not In Conflict Over The Application Of The "Savings Clause"..... 24

III. NO SPECIAL OR IMPORTANT REASONS EXIST FOR GRANTING THE PETITION FOR WRIT OF CERTIORARI..... 26

CONCLUSION 29

TABLE OF AUTHORITIES

Page

CASES

Aetna Life Ins. Co. v. Borges, 869 F.2d 142 (2d Cir.) *cert. denied*, 493 U.S. 811 (1989) 22

Airparts Co., Inc. v. Custom Benefit Services of Austin, Inc., 28 F.3d 1062 (10th Cir. 1994) 21

Ball v. Life Planning Services, Inc., 187 W.Va. 682, 421 S.E.2d 223 (1992) 9, 16

Clark v. Coats & Clark, Inc., 865 F.2d 1237 (11th Cir. 1989) 21

Consolidated Beef Indus. v. New York Life Ins. Co., 949 F.2d 960 (8th Cir. 1991), *cert. denied*, 112 S.Ct. 1670 (1992) 20

Custer v. Pan American Life Ins. Co., 12 F.3d 410 (4th Cir. 1993) 9

Farlow v. Union Central Life Ins. Co., 874 F.2d 791 (11th Cir. 1989) 16, 20

First National Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc., 960 F.2d 1546 (11th Cir. 1992), *cert. denied*, 113 S.Ct. 1045 (1993) 20

FMC Corp. v. Holliday, 498 U.S. 52 (1990) 25, 26

Hermann Hospital v. MEBA Medical & Benefits Plan, 845 F.2d 1286 (5th Cir. 1988) 23

Hogan v. Kraft Foods, 969 F.2d 142 (5th Cir. 1992) 16

TABLE OF AUTHORITIES – Continued

Page

Ingersoll-Rand v. McClendon, 498 U.S. 133 (1990)...14, 15

International Resources v. New York Life Ins. Co., 950 F.2d 294 (6th Cir. 1991), *cert. denied*, 112 S.Ct. 2941 (1992).....17, 25, 26

Keel v. Group Hospitalization Medical Services, Inc., 695 F.Supp. 223 (E.D. Va. 1988).....17

Martori Bros. Distributors v. James-Massengale 781 F.2d 1349 (9th Cir. 1986), amended, 791 F.2d 799, *cert. denied*, 479 U.S. 949 (1986).....22

Monarch Cement v. Lone Star Indus., 982 F.2d 1448 (10th Cir. 1992).....22

Moore v. Provident Life & Accident Ins. Co., 786 F.2d 922 (9th Cir. 1986).....16

Perkins v. Time Ins. Co., 898 F.2d 470 (5th Cir. 1990).....21, 22

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).....9, 18, 21, 25, 26

Powell v. Chesapeake & Potomac Telephone Co., 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170.....17

Rebaldo v. Cuomo, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).....23

Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983)...20, 23

Swerhun v. Guardian Life Ins. Co. of America, 979 F.2d 195 (11th Cir. 1992).....16

Tri-State Machine Co., Inc. v. Nationwide Life Ins. Co., 33 F.3d 309 (4th Cir. 1994).....9

Whitworth Bros. Storage Co. v. Cent. States Pension Fund, 794 F.2d 221 (6th Cir. 1986), *cert. denied*, 479 U.S. 1007 (1986).....23

TABLE OF AUTHORITIES – Continued

Page

STATUTES

28 U.S.C. § 1292(b) 8
29 U.S.C. § 1144 13
29 U.S.C. § 1144(a) 14, 15
29 U.S.C. § 1144(b)(2)(B) 18
W. Va. Code § 33-11-1 *et seq.* 16
W. Va. Code § 33-11-2 1
W. Va. Code § 33-11-3 ..... 1, 17
W. Va. Code § 33-11-4(9) 2, 17
W. Va. Code § 33-11-5 3

RULE

Supreme Court Rule 15.1 4

STATUTES WHICH THE CASE INVOLVES

Article 11, Chapter 33, West Virginia Code, in pertinent part herein, reads as follows:

§ 33-11-2. Definitions.

As used in this article:

(a) "Person" includes any individual, company, insurer, association, organization, society, reciprocal, business trust, corporation, or any other legal entity, including agents and brokers. "Person" also includes hospital service corporation, medical service corporations and dental service corporations as defined in article twenty-four [§ 33-24-1 *et seq.*] of this chapter, and health care corporations as defined in article twenty-five [§ 33-25-1 *et seq.*] of this chapter. For purposes of this article hospital service corporations, medical service corporations, dental service corporations, and health care corporations shall be deemed to be in the business of insurance.

(b) "Commissioner" means the insurance commissioner of West Virginia.

(c) "Insurance policy" or "insurance contract" means the contract effecting insurance, or the certificate thereof, by whatever name called, and includes all clauses, riders, endorsements and papers attached thereto and a part thereof. (1957, c. 94; 1974, c. 51).

§ 33-11-3. Unfair methods of competition and unfair or deceptive acts or practices prohibited.

No person shall engage in this State in any trade practice which is defined in this article as, or determined pursuant to section seven [§ 33-11-7] of this article to be, an unfair method of competition or an unfair or deceptive

act or practice in the business of insurance. (1957, c. 97; 1974, c. 51).

§ 33-11-4. Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

* * *

(3) Defamation. No person shall make, publish, disseminate or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person and which is calculated to injure such person.

* * *

(5) False statements and entries. (a) No person shall knowingly file with any supervisory or other public official, or knowingly make, publish, disseminate, circulate or deliver to any person, or place before the public, or knowingly cause directly or indirectly, to be made, published, disseminated, circulated, delivered to any person or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) No person shall knowingly make any false entry of a material fact in any book, report or statement of any person or knowingly omit to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

§ 33-11-5. Favored agent or insurer; coercion of debtors.

(a) No person may:

(1) Require, as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or agent or broker or group of agents or brokers;

(2) Unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien;

(3) Require directly or indirectly that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge, in connection with the handling of any insurance policy required as security for a loan on real estate, or pay a separate charge to substitute the insurance policy of one insurer for that of another; or

(4) Use or disclose information resulting from a requirement that a borrower, mortgagor or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of the mortgagee, vendor, or lender, or is to the detriment of the borrower, mortgagor, purchaser, insurer, or the agent or broker complying with such a requirement.

* * *

(b)(4) For purposes of this section, "person" includes any individual, corporation, association, partnership, or other legal entity. (1957, c. 97; 1974, c. 51)

STATEMENT OF THE CASE

The Factual Background

Pursuant to Supreme Court Rule 15.1, and in fairness to the parties, it is necessary to briefly examine a number of factual inaccuracies asserted by Petitioner Tri-State Machine Company, Inc. ("Tri-State") to this Court in its Petition for Writ of Certiorari ("Petition") as well as examine the true nature of the relationship the parties shared.

The arrangement entered into by Respondent Nationwide Life Insurance Company ("Nationwide") and Tri-State is what is commonly called a minimum premium plan. The minimum premium plan was an alternative funding arrangement to traditional insurance which lowered Tri-State's insurance costs versus traditional insurance. The arrangement meant that Nationwide would provide administration of health, life, prescription drug, dental and disability insurance claims submitted by participants, dependents and beneficiaries of the employee welfare benefit plan established by Tri-State for its employees.

The documents which created the relationship between Nationwide and Tri-State were the contract of insurance and a Funding Agreement. The two documents, taken together, provided that Nationwide would determine the validity of claims submitted for payment under the plan. Validity was determined in accordance with the policy of insurance issued by Nationwide. Nationwide would decide whether a claim was payable and, if so, the amount that was payable. Whether a claimant was eligible to receive benefits under the plan was based upon Tri-State's decision, as plan sponsor, which classes of employees were to receive certain levels of benefits. Moreover, the information Nationwide had with

regard to eligibility was provided to Nationwide at least monthly by Tri-State.

Nationwide hired a third-party administrator to adjudicate claims in accordance with written plan terms. The decision to seek the services of a third-party administrator in such a relationship is not unusual. Upon the claims decision, Nationwide paid claims out of its own funds. Monthly, Nationwide would compile and send to Tri-State a summary of charges (the claims) paid by Nationwide and would also send a premium billing statement showing amounts due for each participant, dependent and beneficiary enrolled in the plan. The summary of charges and the premium billing statement together comprised the amount Tri-State owed to Nationwide for the prior month. These amounts together is what Tri-State generically refers to in its Petition as "premium." Tri-State's liability was limited to its monthly and yearly aggregate stop-loss amounts.

Tri-State sponsored and funded the employee welfare benefit plan, and retained the discretion to determine how the plan was funded, the kinds of coverage that would be available to its employees, who would be covered, at what levels they would be covered and the ability to alter coverage.

Consistent with this arrangement, Nationwide undertook to process hundreds of claims for benefits submitted by the plan participants of the Tri-State employee welfare benefit plan between July 1, 1987 and July 1, 1989. The relationship continued until July, 1989 when Nationwide terminated the agreement pursuant to the termination provisions contained in the contract.

The contract of insurance and the Funding Agreement necessarily have to be read in conjunction to determine and understand the rights and liabilities the parties

shared during the time the agreement was in force. In order to determine the amounts that would be due from Tri-State to Nationwide for premium and claims liability up to the stop-loss amount, and determine whether Tri-State or Nationwide had honored their mutual obligations under the plan, the policy of insurance and the Funding Agreement would have to be read together.

Because Tri-State has chosen in this litigation to wage its fight against Nationwide through pleadings and motions only, the merits of the instant case have never been brought before a trier of fact. As such, a number of "facts" alleged by Tri-State in its Petition to this Court are nothing more than baseless, unsupported attacks. So that the Court is not misled into accepting as fact the unfounded allegations made by Tri-State, Nationwide points out a number of inaccuracies asserted by Tri-State in the Petition.

It is not true, as Tri-State asserts at page 6 of its Petition, that Nationwide in any way acted dishonestly toward Tri-State or to the plan. Nor did Nationwide, at any time, manipulate posting dates of claims for any reason. Further, Nationwide never intentionally reported claims to Tri-State later than they were actually paid. At all times, Nationwide acted in the best interests of Tri-State and consistently with its express obligations under the agreement in administering Tri-State's employee welfare benefit plan.

Additionally, it is not true that what Tri-State seeks is a remedy for fraud in the sale of insurance and fraud in the computation of premiums as asserted at various times in its Petition. From the first instance of filing the litigation below, Tri-State alleged that Nationwide had administered claims under the plan incorrectly, that Nationwide had breached its fiduciary duty to Tri-State

under the plan, and that, as a result, Tri-State and the plan suffered damages. (See, e.g. Complaint, App. 1a-10a; Statement of Facts in Plaintiff's Memorandum of Law in Support of Motion to Remand, App.15a-16a). Only since appealing the district court's judgment to the Fourth Circuit Court of Appeals, and now to this Court, has Tri-State attempted to characterize this case as one for fraud in the sale of insurance or fraud in the computation of insurance premium. The pleadings and motions filed by Tri-State in the litigation below allege misadministration of claims submitted to the plan by plan participants and beneficiaries, allegedly resulting in miscalculated premiums which were charged to Tri-State.

The Case Below

On February 26, 1990, Tri-State filed a five-count complaint against Nationwide in the Circuit Court of Ohio County, West Virginia. The complaint alleges that Nationwide negligently and purposefully mismanaged the administration of an employee benefit plan which was created by Tri-State to provide health and accident benefits for its employees. Nationwide timely removed the case to the United States District Court for the Northern District of West Virginia, based on diversity jurisdiction and federal question jurisdiction under ERISA.

One of the affirmative defenses asserted by Nationwide was that this action was wholly preempted by ERISA. On April 23, 1991, Tri-State submitted its Motion For Partial Summary Judgment which sought a finding that its complaint was not preempted by ERISA. On September 23, 1991, the district court issued its Memorandum Opinion and Order which found that Tri-State's

complaint " . . . clearly relates to an employee welfare benefit plan," and was therefore preempted by ERISA. Tri-State sought reconsideration of this order, or, alternatively, certification for an interlocutory appeal.

The district court denied Tri-State's request for reconsideration of summary judgment, but certified the ERISA preemption issue for an interlocutory appeal under 28 U.S.C. § 1292(b). Tri-State submitted a Petition For Permission To Appeal to the Fourth Circuit Court but this petition was denied on March 26, 1992.

On April 6, 1992, Tri-State submitted its Motion to Vacate and Reenter Order. This motion sought permission from the district court for another interlocutory appeal on the issue of ERISA preemption. The district court denied this motion, and "ORDERED that the plaintiff inform the Court within thirty (30) days of entry of this Order whether it intends to pursue this action under ERISA." Tri-State submitted a Notice on July 8, 1992, which informed the court that "plaintiff intends to pursue this action under ERISA."

Nine months after submitting its notice of intent to proceed under ERISA, Tri-State filed a Motion To Amend the Complaint, which yet again sought to escape ERISA preemption. This motion sought to change two factual allegations made three years earlier by Tri-State upon which the district court relied in holding that ERISA preempted this action. Filed simultaneously with its Motion To Amend was Tri-State's Conditional Motion For Entry of Final Summary Judgment And Request For Entry of Final Judgment. This last motion sought final judgment on the ERISA preemption issue so as to allow an immediate appeal. In the alternative, the motion sought, for a third time, summary judgment that Tri-State's complaint was not preempted by ERISA. On July

2, 1993, the district court entered the order which held again that ERISA wholly preempted Tri-State's state law causes of action. The court stated:

> In that this issue has been repeatedly and exhaustively briefed, in that Tri-State has fully defended and has presented all material pertinent to its claim, and since Tri-State has failed to seek leave to amend its complaint to assert an ERISA claim, the court hereby GRANTS summary judgment *sua sponte* for Nationwide, and hereby DISMISSES this action.

From this order, Tri-State appealed to the Fourth Circuit Court of Appeals.

The issues raised by Tri-State were briefed, and the Fourth Circuit Court heard oral argument on March 9, 1994. The court affirmed the decision of the district court on August 31, 1994, specifically finding that Tri-State's common and statutory law claims related to the subject employee welfare plan and were not saved from preemption. Noting its decision in *Custer v. Pan American Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993) (applying *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987)), and the decision in *Ball v. Life Planning Services, Inc.*, 187 W.Va. 682, 421 S.E.2d 223 (1992), the court concluded that the West Virginia Unfair Trade Practices Act was likewise not saved from preemption.

Upon further reviewing the procedural history of the case, the appeals court had no problem finding that the district court did not abuse its discretion in " . . . bringing this tortured pleading battle to an end." *Tri-State Machine Co., Inc. v. Nationwide Life Ins. Co.*, 33 F.3d at 315.

SUMMARY OF THE ARGUMENT

Nationwide respectfully requests that this honorable Court deny Tri-State's Petition for a Writ of Certiorari seeking review of the decision of the Fourth Circuit Court of Appeals in this case since no error was committed by the courts below in deciding that Tri-State's claims were preempted by ERISA and since there are no issues raised by Tri-State that warrant review by this Court.

Tri-State's argument in support of its Petition to the Court apparently is that it has been deprived, because of congressionally mandated federal preemption of ERISA claims, the choice of state law remedies it would *prefer* to have against Nationwide to compensate Tri-State for its perceived injury. There is not any serious question that Tri-State had the ability, at the time it initiated this litigation and since, to seek redress under ERISA to correct perceived wrongs within the relationship Tri-State and Nationwide shared, although Tri-State argues to the contrary. Tri-State is most concerned that the supremacy of federal law over state law prevents it from seeking the state common law and statutory remedies it believes should be available to it to pursue against Nationwide despite the federal nature of the claims.

Consequently, Tri-State concocts a weak and obtuse argument about the lack of available remedies and the lack of a forum when it has been clear since the inception of this litigation that Tri-State had the ability to pursue the express relief provided under ERISA's civil enforcement provisions, ERISA § 502, or under the emerging federal common law the courts have developed under ERISA. This fact is evident enough that Tri-State cites to precedent for federal common law relief afforded for ERISA violations. (See e.g., p. 16 of Tri-State's Petition).

Tri-State asks this Court to accept this case and redefine the parameters of federal preemption of ERISA claims absent congressional mandate. The posture assumed by Tri-State is that even though this Court and the circuit courts of appeal adhere to the established principles of ERISA preemption in accordance with the letter and spirit of ERISA, the Court should now obliterate those principles in favor of an idea that requires preemption of claims made by ERISA plan participants against a plan fiduciary, but not of claims made by plan sponsors or plan fiduciaries against a plan fiduciary, in cases where the claims are indistinguishable.

Congress, in enacting ERISA, could not have envisioned such an arbitrary distinction. This is acutely apparent when one considers the sweeping scope of ERISA's preemption provisions. To have the relief Tri-State suggests ought to be afforded it in this case would require action by Congress, not action by this Court.

Moreover, there is not a conflict in the circuits, as suggested by Tri-State, with regard to applying the "relates to" test for preemption or with regard to applying the "savings clause." Cases decided by this Court and the circuit courts of appeal consistently apply the law of preemption and adhere to its tenets.

Under the sound and consistently applied law of ERISA preemption, as it has been articulated and applied by this Court and the circuit courts of appeal, Tri-State's claims against Nationwide "relate to" the subject employee welfare benefit plan and are therefore preempted by ERISA. Moreover, Tri-State's allegations of breach of contract, breach of implied covenants of good faith and fair dealing, bad faith, and violation of the West Virginia Unfair Trade Practices Act are laws of general application and do not regulate the business of insurance.

Consequently, Tri-State's claims are not "saved" from preemption.

ARGUMENT

I. THE CLAIMS MADE BY TRI-STATE IN THIS LITIGATION RELATE TO THE SUBJECT EMPLOYEE WELFARE BENEFIT PLAN, ARE PREEMPTED BY ERISA AND ARE NOT SAVED FROM PREEMPTION

Throughout its Petition, Tri-State asserts that it alleged fraud in the sale of insurance and that the courts below determined those claims were preempted. In this manner, Tri-State attempts to disguise the issues it actually raised in the district and appeals courts. Tri-State suggests to this Court that its pleas to the lower courts to address the issues of fraud in the *sale* and in *computation of premium* have been ignored, when the nature of the claims brought by Tri-State and the relief it has sought all along in its pleadings and motions necessarily involve construction of the subject plan terms to decide whether the plan was administered properly or whether Tri-State was correctly charged for the benefit it sought in its relationship with Nationwide. Tri-State's argument that its claims were ignored by the courts below is disingenuous.

It is not disputed that the subject plan is an employee welfare benefit plan governed by ERISA. Nor, can it be seriously disputed that the claims asserted by Tri-State against Nationwide "relate to" the plan in that the claims implicate plan administration and Nationwide's duties to Tri-State and the plan under express plan terms. Consequently, Tri-State's state common law and statutory law claims are preempted by ERISA. Moreover, those claims are not saved from preemption under ERISA § 514, 29

U.S.C. § 1144 since the state laws involved apply generally to, and do not regulate, the business of insurance.

A. Tri-State's Claims Clearly "Relate To" The Subject Employee Welfare Benefit Plan

In the Complaint it filed on February 26, 1990, Tri-State alleged a series of claims which it asserted had caused damage to Tri-State, the Tri-State employee welfare benefit plan and the participants and beneficiaries of the plan. The factual allegations and claims Tri-State raised in the Complaint include: Nationwide's duty to administer the plan (para. 11, App. 2a); the calculation of Tri-State's liabilities under the contract on the basis of claims paid (para. 16, App. 3a); Nationwide's failure to timely process claims under the subject employee benefit plan (para. 17, App. 3a); Nationwide's fiduciary duty to Tri-State pursuant to the plan and breach of that duty (paras. 20, 30 App. 4a, 6a); Nationwide's failure to administer the plan in accordance with plan terms (para. 21, App. 4a); Nationwide's payment of claims to the wrong medical providers, erroneously issuing coverage cards, erroneously charging claims, improperly paying and denying claims and delaying processing claims (para. 22, App. 4a-5a); incorrectly calculating Tri-State's liabilities and premiums under the plan (paras. 23, 26, 27, App. 5a); the financial detriment caused to Tri-State and its plan's participants as the result of Nationwide's alleged failure to perform its duties under the plan (paras. 31, 32, 35, App. 6a); and Nationwide's consequential breach of its obligations to Tri-State under the plan (paras. 42, 44, App. 7a, 8a).

These claims were raised and at issue before the district court. Moreover, Tri-State reaffirmed these as its core allegations when it sought remand of the case to

state court. (See Statement of Facts, in Plaintiff's Memorandum of Law in Support of Motion to Remand, App. 15a-16a).

The expansive sweep of ERISA's preemption provision is practically axiomatic. When it enacted ERISA, Congress intended to preempt the field of employee benefit regulation completely, and provided that all state laws which relate to an ERISA plan are superseded by federal law.

In 1974, Congress enacted ERISA, which reserves to federal law the entire task of regulating employee benefit plans. ERISA's most sweeping safeguard, which secures the rights and expectations of the entities protected by ERISA, is the supercedure provision at 29 U.S.C. Section 1144(a).

The expansiveness of preemption has been articulated and affirmed time and again by this Court and the other federal courts. The scope of ERISA preemption is characterized in *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990), wherein the Court, in reviewing Congress' intent in drafting ERISA's preemption provision, stated:

> "The pre-emption clause is conspicuous for its breadth." . . . Its "deliberately expansive" language was "designed to 'establish pension plan regulation as exclusively a federal concern.' " . . . The key to § 514(a) is found in the words "relate to." Congress used those words in their broad sense, rejecting more limited pre-emption language that would have made the clause "applicable only to state laws relating to the specific subjects covered by ERISA." . . . Moreover, to underscore its intent that

> § 514(a) be expansively applied, Congress used equally broad language in defining the "State law" that would be pre-empted. Such laws include "all laws, decisions, rules, regulations, or other State action having the effect of law." § 514(c)(1), 29 U.S.C. § 1144(c)(1). [citations omitted]

498 U.S. at 138, 111 S.Ct. at 482-483, 112 L.Ed.2d at 479.

In *Ingersoll-Rand*, the unanimous Court addressed the question of determining whether a state court cause of action "relates to" an ERISA plan. The Court expressed a rather uncomplicated standard for that determination: if the existence of an ERISA plan is a critical factor in establishing liability, then the action most assuredly relates to an ERISA plan. *Ingersoll-Rand*, 498 U.S. at 140, 111 S.Ct. at 483, 112 L.Ed.2d at 479. Where a court's inquiry "must be directed to the plan," the cause of action relates to an ERISA plan and is preempted. *Id.*

Tri-State's Complaint unequivocally relates to an ERISA plan. Every allegation asserted in the complaint directly implicates the administration and operation of Tri-State's employee welfare benefit plan. The allegations of misadministration of claims, breach of duty relating to claims handling and damages occasioned thereby relate to the plan. The existence of an ERISA plan and construction of its express terms are critical factors in determining whether liability exists. A court's inquiry must be directed to the plan, and therefore Tri-State's state law actions relate to the ERISA plan. The evaluation used by the Court in *Ingersoll-Rand* illustrates Tri-State's allegations are preempted by 29 U.S.C. § 1144(a).

B. The State Law Claims Asserted By Tri-State Are Not Saved From Preemption

The West Virginia Supreme Court has determined that Chapter 33-11-1 *et seq.* is preempted by ERISA, and not saved by the savings clause. In *Ball v. Life Planning Services, Inc.*, 187 W.Va. 682, 421 S.E.2d 223 (1992), the court stated:

> [Plaintiff's claim under W.Va. Code § 33-11-4(9)] relates to unfair claim settlement practices and is clearly the same type of claim that the United States Supreme Court found to be preempted by § 514(a) of ERISA in *Pilot Life Insurance Co. v. Dedeaux*.

Id. at 227. The Supreme Court of West Virginia has made clear its position that its state's Unfair Trade Practices Act is preempted by ERISA. This is so despite the purpose enunciated by the West Virginia legislature in the preamble to West Virginia's unfair trade practices act which purports to purpose the Act to regulate the business of insurance.

Because of their general application, state laws which provide statutory causes of action against insurers for unfair practices do not generally regulate the business of insurance and are not saved from preemption by ERISA's savings clause. Alabama's statutory laws, which prohibit misrepresentation and deceptive practices of insurers are not saved and are preempted, as such statutes do not regulate insurance. *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989); also see *Swerhun v. Guardian Life Ins. Co. of America*, 979 F.2d 195 (11th Cir. 1992) (Florida insurance deceptive trade practices statutes preempted by ERISA). State statutory laws of Texas under the Deceptive Practices Act and Insurance Code are preempted by ERISA. *Hogan v. Kraft Foods*, 969 F.2d 142 (5th Cir. 1992); also see, *Moore v. Provident Life & Accident Ins.*

Co., 786 F.2d 922 (9th Cir. 1986) (California unfair claims settlement statute preempted by ERISA); *International Resources v. New York Life Ins.*, 950 F.2d 294 (6th Cir. 1991) (Kentucky unfair and deceptive practices statutes preempted by ERISA).

In *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170, the court held that the Virginia Unfair Trade Practices Act, portions of which dealt specifically with misrepresentation by insurance companies, was preempted by ERISA, and was not saved by the savings clause. The court in *Powell* found that the Virginia statutes did not regulate insurance as specified in Section 1144. Also see, *Keel v. Group Hospitalization Medical Services, Inc.*, 695 F.Supp. 223 (E.D. Va. 1988).

Similarly, West Virginia's unfair trade practices act applies generally to insurers and other persons and does not only regulate the business of insurance. For example, § 33-11-3 provides that "no person" shall engage in an unfair method of competition. § 33-11-4 prohibits "any person" from defaming another and making false statements and entries regarding another's financial condition. Other provisions of the West Virginia statute likewise have application generally to both those within and those outside the business of insurance. Clearly, the West Virginia unfair trade practices statute does not regulate the business of insurance.

The remaining claims asserted by Tri-State in the instant case, those brought under West Virginia common law, are not saved from preemption by ERISA since those claims apply generally to all types of actions which may be brought in that state. Thus, Tri-State's common law claims of breach of contract, breach of implied covenants of good faith and fair dealing, bad faith and breach of

duty are not saved from preemption under ERISA. See *Pilot Life Ins. Co v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987).

C. The Deemer Clause Is Inapplicable To This Case

This Court need not reach the issue of when an employee welfare benefit plan is self-funded and when it is fully insured for any purpose, including the purpose of deciding whether the "deemer clause," 29 U.S.C. § 1144 (b)(2)(B), applies to this case. The "deemer" argument has unnecessarily been brought into this case because the state law which Tri-state alleges has been violated is not saved from preemption. Tri-State's deemer argument is premised upon whether the plan at issue is self-funded or fully insured. The Fourth Circuit in this case, and other circuits, have determined that a self-funded plan does not lose its character upon the purchase of stop-loss insurance alone. Here, Tri-State has not sought to demonstrate whether its plan was self-funded or fully insured prior to entering into the relationship with Nationwide. Without this showing, Tri-State cannot avail itself of an argument that the courts below have incorrectly concluded the Tri-State plan is self-funded.

Moreover, it is clear from Tri-State's Petition that it misapprehends the preemption analysis as applied to the deemer clause. At pages 27-28 of the Petition, Tri-State suggests that the Fourth Circuit court in the case below applied the deemer clause analysis " . . . to prevent the 'saving' of any state law causes of action." This is a clear misstatement of the lower court's ruling and it reveals that Tri-State is unclear as to how the deemer clause was applied to the preemption analysis in this case. Both the district court and circuit court of appeals determined that

Tri-State's state law claims were not saved from preemption. The courts did not need to explore the application of the deemer clause to "prevent the 'saving' " of the causes of action asserted. Once the courts determined that the laws in question were not saved, no further preemption analysis was required. As the Fourth Circuit court points out in its opinion, the district court recognized that the deemer clause could be an alternative basis to find that Tri-State's state law claims were preempted. The circuit court of appeals found no reason to disturb the district court's conclusion, and doing so would have no impact on the conclusions reached in the instant case.

II. THERE IS NO CONFLICT IN THE CIRCUITS OVER THE APPLICATION OF THE "RELATES TO" DOCTRINE OR THE "SAVINGS CLAUSE"

The cases Tri-State cites, claiming conflict over the application of the preemption analysis, deal with issues and facts as diverse as their number. A review of the cases cited by Tri-State shows that the circuits are not in conflict over the application of the "relates to" test and the application of the "savings clause"; rather, in reviewing those cases, it is readily apparent how consistently the courts have applied and continue to apply the law of preemption in ERISA cases.

Tri-State would ask this Court to disregard mandated federal preemption of ERISA claims on the basis that the cases which apply the "relates to" test and the "savings clause" are inconsistently applied. But Tri-State's prayer is offered in a case where the claims it brought before the courts below directly implicate the administration of a plan governed by ERISA and where the law is not saved

from preemption. Tri-State attempts to disguise its claims so as to make its plea more appealing.

A. The Circuit Courts Are Not In Conflict Over When A Claim "Relates To" A Plan

Tri-State cites *Consolidated Beef Indus. v. New York Life Ins. Co.*, 949 F.2d 960 (8th Cir. 1991), *cert. denied*, 112 S.Ct. 1670 (1992) at page 17 of its Petition. In that case the court, noting that the Plaintiff's claims were for improper plan administration, recognized the broad preemption provision contained in ERISA and that state law claims for improper plan processing are preempted. *Id.* at 963. The court further recognized that since ERISA allows equitable relief against both fiduciaries and non-fiduciaries, Congress intended preemption to apply even where no ERISA remedy existed. 949 F.2d at 964.

In *First National Life Ins. Co. v. Sunshine-Jr. Food Stores, Inc.*, 960 F.2d 1546 (11th Cir. 1992), *cert. denied*, 113 S.Ct. 1045 (1993), cited by Tri-State at page 16 of its Petition, the court rejected plaintiff's argument that its claims of mishandling benefit payments and failure to adhere to terms of the group policy which was part of the subject employee welfare benefit plan did not "relate to" the plan. Quoting *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 97, 103 S.Ct. 2890,2900, the court stated: "Congress used the words 'relate to' in their broad sense and did not mean to preempt only state laws specifically designed to affect employee benefit plans. . . . A state law relates to an employee benefit plan if it 'has a connection with or reference to such a plan.' " *Id.* at 1550.

In *Farlow v. Union Cent. Life Ins. Co.*, 875 F.2d 791 (11th Cir. 1989), beneficiaries of an employee welfare benefit plan brought an action against the insurer and insurance agent alleging fraudulent misrepresentation,

negligence and violation of Alabama's twisting statute. On interlocutory appeal, the Eleventh Circuit stated that a state law cause of action "relates to" an employee benefit plan if the employer's conduct giving rise to such claim was not "wholly remote in content" from the benefit plan. *Id.* at 794, citing *Clark v. Coats & Clark, Inc.*, 865 F.2d 1237 (11th Cir. 1989).

In *Airparts Co., Inc. v. Custom Benefit Services of Austin, Inc.*, 28 F.3d 1062 (10th Cir. 1994), cited by Tri-State at pages 17 and 18 of its Petition, the court acknowledged that the ERISA preemption provision is "deliberately expansive." *Id.* at 1065. The court further stated that what triggers ERISA preemption is not just any indirect effect on administrative procedures but rather an effect on the primary administrative functions of benefit plans, such as determining an employee's eligibility for a benefit and the amount of that benefit. *Id.*

In *Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990), the insured brought an action against the employer's group health insurer and insurance agent for tortious breach of contract. On appeal, Perkins sought to shift the focus of his complaint to Mississippi statutes regulating the sale and solicitation of insurance. In analyzing Perkins' claims against the insurer, the court determined that they related to an employee benefit plan and must fall within the scope of ERISA's preemption clause. The court noted that Perkins' complaint, which alleged tortious breach of contract as its sole cause of action, clearly mirrors that which *Pilot Life* has held to be preempted under ERISA. As to the claim for fraudulent inducement against the insurance agent, the court found that state law did not affect the relations among the *principal ERISA entities* (the employer, the plan fiduciaries, the plan, and

the beneficiaries), was only indirectly related to the plan and was not preempted by ERISA.

In *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.), *cert. denied*, 493 U.S. 811 (1989), the court held that the Connecticut escheat law at issue was too tenuous, remote and peripheral to require preemption under Section 514(a). Because the Connecticut escheat law at issue applies to lost and abandoned property generally and does not focus on ERISA benefit plans, the court determined that the law was not preempted.

Like the court in *Perkins, supra*, the court in *Monarch Cement v. Lone Star Indus.*, 982 F.2d 1448 (10th Cir. 1992), found no preemption of a dispute between the buyer of a company and the seller over the allocation of responsibility for certain employee benefits under the contract of sale. The court found that the dispute was limited to assessing the relative responsibilities of the parties for payment and did not affect the administration of the plan or the relationship between the principal ERISA entities.

Those cases are wholly distinguishable from the case at bar, since the instant case directly involves the principal ERISA entities (plan sponsor and plan fiduciary) and since the administration of the subject plan is directly implicated.

Another case which Tri-State cites in support of its position that the circuits are in conflict over the application of the "relates to" test is *Martori Bros. Distributors v. James-Massengale*, 781 F.2d 1349 (9th Cir.), amended, 791 F.2d 799, *cert. denied*, 479 U.S. 949 (1986). In that case the California Agricultural Relations Board reviewed a question of unfair labor practice claims regarding alleged failure to bargain in good faith. In affirming a district court's grant of summary judgment for the Board, the

Ninth Circuit held that ERISA did not preempt the calculation of a make-whole award on the basis of fringe benefits. However, the court noted that the principal underlying decisions regarding preemption of state laws appears to be that " . . . the state law is preempted by Section 514(a) if the conduct sought to be regulated by the state law is 'part of the administration of an employee benefit plan'; that is, the state law is preempted if it regulates the matters regulated by ERISA: disclosure, funding, reporting, vesting and enforcement of benefit plans." *Id.* at 1357-58.

In *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), an action by an employee benefit plan against the State of New York was brought challenging a statute which prohibited hospitals from establishing in-patient charges for self-insured employee benefit plans other than authorized by statute. The statute was enacted as a demonstration project to contain hospital costs under Medicaid and Medicare. Quoting *Shaw v. Delta Airlines*, 103 S.Ct. at 2901, the court determined that New York's decision to regulate the amounts a hospital can charge affected employee benefit plans in too tenuous, remote or peripheral manner to warrant a finding that the law relates to the plan. 749 F.2d at 138.

In *Whitworth Bros. Storage Co. v. Cent. States Pension Fund*, 794 F.2d 221 (6th Cir. 1986), *cert. denied*, 479 U.S. 1007 (1986), the court determined that federal common law actions were available to an employer who sued to recover payments to an employee retirement plan made in error. The scope of ERISA preemption is so broad as to displace state law causes of action for which ERISA does not provide a specific remedy.

In *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988), the court noted that ERISA

preempts all state law claims which relate to an employee benefit plan although limited exceptions to this broad preemption were also enacted. The court noted that the narrow issue in the case was whether the state common law causes of action for breach of fiduciary duty, negligence, equitable estoppel, breach of contract and fraud alleged by Hermann Hospital related to the MEBA plan, or whether they were too tenuous, remote and peripheral to the plan to be preempted.

Here, as in the other cases cited above, the test employed by the court dealt directly with the relationship of the claims to the employee benefit plan at issue.

It is important to recognize that the cases cited by Tri-State as being in conflict are quite different factually from each other and quite different factually from the instant case. A review of the underlying ERISA preemption principles contained in those cases shows they are not in conflict. The courts have consistently applied the law as it has been outlined by this Court. Consistently, the courts have held that if plan administration is implicated, if a claim has a connection to a plan and is not too remote or peripheral to a plan, and if the claims involve the principal ERISA entities, that claim relates to the plan under the broad sweep of ERISA preemption Congress designed.

B. The Circuits Are Not In Conflict Over The Application Of The "Savings Clause"

Tri-State lashes out at the circuit court of appeals in the case below claiming that it " . . . perfunctorily applied the McCarran-Ferguson test . . . and reached the conclusion that Congress intended to displace state law that would otherwise provide an employer with remedies against an insurance company from whom the employer

purchased insurance." (Petition at p. 23) Here again, Tri-State attempts to mask the true nature of the claims it asserted against Nationwide and does not reveal them in a true context. In a true context, the context of ERISA, this cause is not properly characterized as a conflict between an employer and an insurer; rather, the conflict is related to an employee welfare benefit plan and is a dispute between a plan sponsor and plan fiduciary over plan administration and duties associated with written, express plan terms.

Tri-State compares the determination reached by the district court and Fourth Circuit court in the instant litigation to a case decided on wholly different facts, *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1992), *cert. denied*, 112 S.Ct. 2941 (1992), claiming that the two cases reveal a conflict between the circuits as to the application of the "savings clause." Nowhere is there any analysis or argument by Tri-State that would support the proposition that the savings clause is misapplied by the courts. Indeed, Tri-State does not attempt to show, in any way, how the case below and *International Resources* reveal a conflict on the application of the savings clause by the courts. The case below and *International Resources*, are so diverse factually that a comparison cannot be reasonably made. *International Resources* deals with a claimed injury arising out of a proposed cancellation of a group health policy of insurance. The instant case deals with the manner in which a plan of insurance governed by ERISA was administered. Both cases apply an analysis of the "savings clause." While the Fourth Circuit determined that Tri-State's claims were not saved from preemption on the guidance of *Pilot Life*, which the court correctly applied, the Sixth Circuit court looked to the guidance provided by *FMC Corp. v. Holliday*,

111 S.Ct. 403, (1990), and correctly applied the instruction provided by that case. As both *Pilot Life* and *FMC v. Holliday* soundly and consistently apply the preemption analysis, one cannot reasonably conclude that the instant case and *International Resources* signal a conflict among circuits on the application of the savings clause.

III. NO SPECIAL OR IMPORTANT REASONS EXIST FOR GRANTING THE PETITION FOR WRIT OF CERTIORARI

It must be reemphasized that Tri-State's case against Nationwide, as asserted by Tri-State in the courts below, has nothing to do with claimed irregularities in the sale of an insurance product. Tri-State complains that this case " . . . is immensely important because it affects the enforceability of every state's Unfair Trade Practices Act against insurance companies in the sale of insurance products." (Petition, p. 10) The case alleged by Tri-State against Nationwide deals strictly with claimed misadministration of and breach of duty under the specific terms of an employee welfare benefit plan Tri-State sponsored. Thus, whether this Court has had " . . . occasion to address the effect of ERISA on regulating the sale of insurance products by insurance companies to employers within the context of employer-sponsored benefit plans. . . . " (Petition, p. 10) is not germane to the issues raised by Tri-State in this litigation, as Tri-State has always maintained that the *administration* of the subject employee benefit plan was inappropriate, not the sale of insurance to the plan sponsor. The claims raised go to the very core of the administrative activity associated with the plan.

The purpose of ERISA preemption is to eliminate difficulty of coordinating administrative activities with respect to employee benefit plans which would occur if plans were subject to different regulations in different states. In enacting ERISA, Congress did not deny states the right to regulate insurers or insurance products; rather, it left unfettered the states' ability to regulate insurance practices. Congress, however, recognized the need to have an established and uniform law to apply to employee benefit plans so as to avoid subjecting plans to inconsistent enforcement schemes under the state laws of the several states. Thus, Congress provided for a broad sweep of laws that would subject employee benefit plans to regulation by the states which was not uniform in application when it enacted ERISA.

Since that time, this court and the circuit courts of appeal have enforced ERISA in accordance with the spirit intended by Congress. The courts have consistently recognized that Congress intended the civil enforcement provisions of ERISA to be the exclusive remedies and have applied the preemption doctrine with a regularity and soundness that promotes the congressional mandate imposed by ERISA. Where ERISA reveals a gap in remedies available, federal common law fills the gap.

Tri-State seeks to have the mandate of preemption obliterated in favor of allowing state law remedies to ERISA litigants in cases which inextricably involve plan administration and the construction of express plan terms in deciding parties' rights under a plan. To allow this would require the Court to undertake a role that is within the sole province of Congress, that of making law. Congress' authority to supplant state law with federal law for the purpose of regulating employee benefits cannot be overridden by the courts, or defined in a manner that is

inconsistent with what Congress intended. Any attempt to redefine the principles and parameters of ERISA, including the parameters of preemption, must be left to Congress.

The Court should not accept this case for review if the effect of doing so would be to redefine ERISA preemption in a way that requires preemption of claims by plan participants against a plan fiduciary but does not require preemption of identical claims by a plan sponsor against a plan fiduciary. This is the course Tri-State proposes the Court follow. Indeed, what Tri-State proposes is to have this Court overturn more than a decade of carefully considered law interpreting and applying the mandates of ERISA to accommodate Tri-State in its quest to seek state law remedies in a case clearly governed by ERISA. What Tri-State proposes the Court do is upset the entire scheme of ERISA preemption in favor of the remedy *it* wants under state law in a case which clearly relates to an employee welfare benefit plan governed by ERISA.

Congress has the authority to redefine the scope and application of ERISA to disputes involving employee welfare benefit plans if it should so choose. Congress has determined that in the area of employee benefits, federal law would supersede the authority of the states to regulate disputes over employee benefit plan administration. To the extent that Congress left regulation of the *business* of insurance to the states, state law may be applied to resolve disputes. Thus Congress, not the courts, must have the say when, and how, ERISA should be redefined, to what it will apply and what exceptions will be carved out.

The role of the courts is to interpret and apply the law that is promulgated, not change it. Nationwide

respectfully submits that the courts have done this consistently and correctly with respect to ERISA preemption and that the instant case brings no issues before this Court which point out the need to examine, or reexamine, the decision reached in this case.

CONCLUSION

At issue is the effect of ERISA preemption upon claims made by a plan sponsor against a plan fiduciary regarding the alleged misadministration of claims made under the plan, breach of duty under the plan and damages occasioned as a result. Tri-State's state law claims relate to the plan and are preempted by ERISA's sweeping supersedure provisions. Further, Tri-State's claims are not saved from preemption.

The courts have consistently applied the ERISA preemption analysis in factually diverse cases and no conflict exists in the circuit courts which gives rise to a need to evaluate the application of ERISA preemption. The instant case is no exception in the way it has been treated by the courts below.

No special or important reasons exist for granting Tri-State's Petition. The issues relating to this case are settled and no special circumstances exist which raise reasons to revisit or redefine the law of ERISA preemption.

For all of the foregoing reasons, Nationwide respectfully submits that the Court should deny Tri-State's Petition.

Respectfully submitted,

PHILIP F. BROWN
(Counsel of Record)
CHORPENNING, GOOD & MANCUSO CO., LPA
77 East Nationwide Boulevard
Columbus, Ohio 43215-2539
(614) 469-1301
Attorneys for Respondent, Nationwide Life Insurance Company

IN THE CIRCUIT COURT OF
OHIO COUNTY, WEST VIRGINIA

TRI-STATE MACHINE, INC., a West Virginia corporation,	:	
Plaintiff,	:	CIVIL ACTION NO.
v.	:	90-C-131B
NATIONWIDE LIFE INSURANCE COMPANY, an Ohio corporation,	:	
Defendant.	:	

COMPLAINT

The plaintiff, for its complaint against the defendant, states and alleges as follows:

COUNT I

(1) The plaintiff, Tri-State Machine, Inc. ("hereinafter "Tri-State"), was, at all times material hereto, a West Virginia corporation doing business in Ohio County, West Virginia.

(2) The defendant, Nationwide Life Insurance Company (hereinafter "Nationwide"), was, at all times material hereto, an Ohio corporation.

(3) The defendant has, prior to, during and subsequent to all times pertinent and relevant to this matter, been engaged in business in the State of West Virginia.

(4) From approximately November of 1983 through approximately July 1 of 1987, Nationwide contracted with

Tri-State to provide group health insurance for Tri-State's employees under a fixed premium plan.

(5) In 1987, Nationwide proposed a method of premium collection under the insurance contract, known as a "minimum premium plan" or "prefunding plan."

(6) Under the proposal deemed a "minimum premium" plan, Tri-State was led to believe that they would be and contractually should have been provided a monthly liability limitation, an individual stop loss protection and a rolling aggregate or yearly maximum out-of-pocket expense limitation under the insurance contract.

(7) On or about July 1, 1987, Nationwide contracted with Tri-State to provide group health insurance under a minimum premium plan for employees of Tri-State, said contract was to expire on June 30, 1988. Said contract was renewed on July 1, 1988, and on July 1, 1989.

(8) Under the policy, Tri-State was self-insured for certain portions of benefits payable under the group health insurance plan.

(9) Under the policy, Nationwide was responsible for certain benefits payable under the insurance contract over and above that portion for which Tri-State was self-insured.

(10) Nationwide collected premiums and derived economic benefits from its insurance contract with Tri-State.

(11) Nationwide had the duty to administer the employee health benefits program for Tri-State pursuant to the contract.

(12) Nationwide's duties included determining what claims should be paid and what claims should not be paid pursuant to the policy terms.

(13) Nationwide directly contracted with First Benefits Agency, Inc. to provide the administration services for the insurance policy in question herein and, more particularly, to administer the direct funding or minimum premium program referred to in previous paragraphs of this Complaint.

(14) Arch Turner, an employee of Nationwide, and Douglas Turner, an employee of First Benefits Agency, Inc., jointly presented the minimum premium plan to representatives of Tri-State. Douglas Turner is the son of Arch Turner.

(15) The agreement by and between Nationwide and Tri-State required, in part, that Nationwide provide monthly reports to Tri-State which would detail Tri-State's liability under the contract.

(16) Tri-State's liability under the contract and the minimum premium program was to be calculated based upon claims paid during any given policy year, subject to an individual and aggregate stop loss.

(17) During the month of July, 1989, Nationwide retroactively terminated the contract to be effective July 1, 1989. Prior to terminating the contract, Nationwide failed to timely process claims with the intent of imposing liability for these claims on Tri-State under the stop loss provisions which were renewed for the new plan year beginning July 1, 1989.

(18) Nationwide deliberately manipulated its calculations and processing of claims in violation of the contract so as to maximize Tri-State's termination liability after improperly terminating said contract as stated herein.

(19) Nationwide has asserted, and continues to assert, that Tri-State is liable for claims incurred and paid by Nationwide prior to termination, said action taken knowingly by Nationwide and directly contrary to the contract.

(20) Nationwide had a fiduciary duty to Tri-State to properly accomplish all duties under the administration program and the insurance contract.

(21) Nationwide did not administer the contract or the minimum funding program according to the terms of the respective contracts.

(22) Nationwide deliberately mismanaged the contract by, among other acts:

(a) Paying claims to the wrong medical providers;

(b) Issuing coverage cards in the names of employees never associated with Tri-State;

(c) Charging claims to the accounts of individuals who had not submitted said claims;

(d) Paying claims not covered;

(e) Denying claims that were covered;

(f) Inconsistently paying or denying claims dependent upon whether they were deemed to be the liability of Nationwide or Tri-State;

(g) Requesting reimbursement from Tri-State for claims improperly paid;

(h) Delayed processing of claims in a year during which Tri-State had met its stop loss liability and thus deflecting claims into a new policy year and thus the claims would become obligations of Tri-State under the renewal stop loss limit.

(23) Nationwide did not calculate Tri-State's monthly, individual and/or yearly liability in accordance with the contract of insurance due to improper administration of the contract.

(24) Nationwide did not provide monthly reports correctly reflecting the calculations concerning Tri-State's liabilites [sic] under the contract.

(25) Nationwide terminated the insurance contract in question in direct disregard and violation of the insurance contract and its provisions and the applicable laws of the State of West Virginia.

(26) Nationwide erroneously calculated premiums due from Tri-State and retroactively terminated the contract based upon a failure to pay the incorrect and erroneously calculated premiums, in violation of the contract and West Virginia law.

(27) Nationwide improperly calculated Tri-State's post-termination liability following the termination of the contract.

(28) Nationwide and First Benefits Agency, Inc., as an agent of Nationwide, manipulated postings to Tri-State's account, improperly calculated the various claims paid and deliberately misinformed Tri-State as to how their liability was calculated, in direct violation of the insurance contract and minimum premium agreement so as to maximize Tri-State's liability under the contract and minimize Nationwide's liability under the contract.

(29) During the contract term, Nationwide unilaterally changed the monthly and yearly stop loss of Tri-State without notice and in direct violation of the contract of insurance.

(30) Nationwide willfully, wantonly, maliciously, intentionally, fraudulently and deceptively breached its fiduciary duty to Tri-State under the contract in question.

(31) Nationwide's violations of the contract have caused Tri-State's employees to devote much time and attention to overseeing the administration of the contract and attempting to ascertain Nationwide's numerous violations thereof, all to the financial detriment of Tri-State.

(32) In doing the acts complained of herein Nationwide has caused harm to the employees of Tri-State, all of whom are third-party beneficiaries of said contract.

(33) Nationwide's cancellation of the contract left all Tri-State employees with *no* health insurance, including those with conditions which prohibited obtaining new coverage, causing great risk of emotional and financial damage.

(34) The actions of Nationwide, all in violation of the contract, have caused Tri-State Machine, Inc. much

aggravation, inconvenience and economic loss, including post-termination economic loss in obtaining new insurance at increased rates.

(35) The violations of the contract by Nationwide have caused Tri-State Machine, Inc. direct economic loss in that a proper administration of the policy would have resulted in a net liability to Tri-State under the policy in an amount lower than the amount ultimately calculated and collected by Nationwide.

(36) Nationwide has admitted that a limited audit requested by Tri-State revealed a twenty-six percent (26%) error rate in the handling of claims under the contract.

(37) Nationwide deliberately, intentionally, recklessly, maliciously and with bad motives failed to inform Tri-State in accordance with the contract.

(38) Nationwide deliberately, intentionally, recklessly, maliciously and with bad motives, failed to provide claims history information necessary for Tri-State to attempt to obtain insurance coverage for employees, following Nationwide's improper termination of the contract.

(39) All actions of Nationwide and First Benefits Agency, Inc., which have resulted in violations of the contract and direct and proximate damages to Tri-State and its owners, were done deliberately, intentionally, negligently, recklessly, maliciously, tortiously, fraudulently, deceptively, defiantly, willfully and wantonly, all said acts being designed to benefit Nationwide at Tri-State's expense.

(40) Nationwide has committed all acts complained of herein with such frequency as to indicate a general business practice of committing said acts.

COUNT II

(41) The plaintiff incorporates by reference all the allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(42) Nationwide has breached its duties and obligations under the insurance contract referenced herein, and as a direct and proximate result thereof, Tri-State has incurred direct economic damages under the contract, consequential damages and legal fees and expenses, for all of which Nationwide is now liable.

COUNT III

(43) The plaintiff incorporates by reference all the allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(44) In doing the acts and actions complained of above, the defendant, Nationwide, has breached implied covenants of good faith and fair dealing embodied in this particular contract, and all insurance contracts, and in doing so, has been negligent, reckless, malicious, tortious, fraudulent, deceptive, defiant, intentional, willful, wanton and deliberate.

COUNT IV

(45) The plaintiff incorporates by reference all the

allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(46) in doing the acts and actions complained of above, the defendant, Nationwide, has acted deliberately, intentionally, willfully, wantonly, recklessly and maliciously, all said actions being a tort independent of all contract actions referenced herein and commonly known as the tort of "bad faith."

COUNT V

(47) The plaintiff incorporates by reference all the allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(48) The plaintiff, Tri-State, is informed and believes that Nationwide is engaged in the business of providing insurance in the State of West Virginia and knowingly committed or performed with such frequency as to indicate a general business practice of the following acts, among others, defined by law as unfair claims settlement practices, in violation of the provisions of the Insurance Code of the State of West Virginia set forth below which were enacted for the benefit and protection of persons and corporations such as the plaintiff herein:

(a) Misrepresented pertinent facts of insurance policy provisions relating to coverages and duties at issue;

(b) Failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) Failed to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(49) In doing so, the defendant, Nationwide, committed a common law and statutory offense of "insurance bad faith."

COUNT VI

(50) The plaintiff incorporates by reference all the allegations contained in Count I above, including paragraphs 1 through 40 as if set forth completely herein.

(51) In doing the acts and omissions complained of as hereinbefore set forth, the defendant, Nationwide, violated the rules and regulations of the Insurance Commissioner of the State of West Virginia and, more specifically, Series XV-V-1981, Unfair Trade Practices, relating to deceptive and unfair trade practices, including unfair claim settlement practices.

PRAYER FOR RELIEF

WHEREFORE, the plaintiff, Tri-State Machine, Inc., demands judgment against Nationwide Life Insurance Company as follows:

(1) Compensatory damages in the sum of One Million Dollars ($1,000,000.00);

(2) Punitive damages in the sum of Ten Million Dollars ($10,000,000.00);

(3) Prejudgment and post-judgment interest on all items of ascertainable pecuniary loss up to and including

the date of trial or payment of the same, attorney fees and costs incurred in an attempt to protect Tri-State Machine, Inc.'s rights under the insurance contract in question;

(4) Judgment against Nationwide Life Insurance Company for all fees, expenses and costs incurred herein;

(5) The plaintiff demands a jury trial on all issues contained herein.

TRI-STATE MACHINE, INC.

By /s/ Ray A. Byrd
Of Counsel

By /s/ Gregory A. Gellner,
Of Counsel

Ray A. Byrd, Esq.
Gregory A. Gellner, Esq.
SCHRADER, STAMP, BYRD,
BYRUM & COMPANION
1000 Hawley Building
Wheeling, WV 26003
(304) 233-3390

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF WEST VIRGINIA
(WHEELING DIVISION)

TRI-STATE MACHINE, INC., a West Virginia corporation,	:	CIVIL ACTION NO. ___
Plaintiff,	:	(Ohio County Circuit Court Civil Action No. 90-C-131 B)
v.	:	
NATIONWIDE LIFE INSURANCE COMPANY, an Ohio corporation,	:	
Defendant.	:	

PLAINTIFF'S MEMORANDUM OF
LAW IN SUPPORT OF MOTION TO REMAND

Ray A. Byrd, Esq.
Gregory A. Gellner, Esq.
SCHRADER, STAMP, BYRD,
BYRUM & COMPANION
1000 Hawley Building
Wheeling, WV 26003
(304) 233-3390

TABLE OF CONTENTS

Pg.

I. STATEMENT OF FACTS 1

II. RELEVANT ERISA PROVISIONS 2

III. DISCUSSION OF LEGAL ISSUES 3

A. 28 U.S.C. § 1331 and 28 U.S.C. § 1441(b) PROHIBIT THIS ACTION FROM BEING REMOVED SINCE PLAINTIFF'S CLAIM IS BASED ON STATE LAW AND DOES NOT INVOKE THE PRINCIPLES OF ORIGINAL JURISDICTION 3

B. 29 U.S.C. § 1132(e) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE THE CIRCUIT COURT OF OHIO COUNTY, WEST VIRGINIA HAS CONCURRENT JURISDICTION OVER PLAINTIFF'S CLAIM 13

C. 29 U.S.C. § 1144(b)(2) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE PLAINTIFF'S CLAIM IS BASED UPON STATE LAW "WHICH REGULATES INSURANCE." 15

D. 28 U.S.C. § 1332(c) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE DIVERSITY OF CITIZENSHIP DOES NOT EXIST 18

IV. CONCLUSION 20

V. AUTHORITIES RELIED UPON

A. *Cases*

Barnhart v. Western Maryland Ry. Co., 128 F.2d 709 (4th Cir. 1942)

Bell v. Amcast Industrial Corp., 607 F. Supp. 486 (S.D. Ohio 1985)

Brough v. United Steelworkers of America, AFL-CIO, 437 F.2d 748 (1st Cir. 1971)

Buchannan v. Delaware Valley News, 571 F. Supp. 868 (E.D. Pa. 1983)

Burgess v. Charlottesville Savings & Loan Ass'n, 477 F.2d 40 (4th Cir. 1973)

Caterpillar, Inc. v. Williams, 482 U.S. 386 (1987)

Champion International Corp. v. Brown, 731 F.2d 1406 (9th Cir. 1984)

Continental Resources and Mineral Corp. v. Continental Ins. Co., 546 F. Supp. 850 (S.D. W.Va. 1982)

Cook v. Georgetown Steel Corp., 770 F.2d 1272 (4th Cir. 1985)

County of Suffolk v. Long Island Lighting Co., 549 F. Supp. 1250 (E.D. N.Y. 1982)

Croy v. Buckeye International, Inc., 483 F. Supp. 402 (D. Md. 1979)

Cuyahoga Co. v. Northern Ohio Co., 252 U.S. 388 (1920)

Eversole v. Metropolitan Life Ins. Co., 500 F. Supp. 1162 (C.D. Cal. 1980)

Ferrell v. Heck's, Inc., 604 F. Supp. 683 (S.D. W.Va. 1985)

Freeman v. Colonial Liquors, Inc., 502 F. Supp. 367 (D. Md. 1980)

Fresh International Corp. v. Agricultural Labor Relations Bd, 805 F.2d 1353 (9th Cir. 1986)

Gully v. First National Bank, 299 U.S. 109 (1936)

Hudler v. Wilson, 376 F. Supp. 592 (D. Colo. 1974)

Hughes v. Blue Cross of Northern California, 263 Cal. Rptr. 850, 215 Cal. App. 3d 832 (1989)

Irving Trust Co. v. Century Export & Import, S.A., 464 F. Supp. 1232 (S.D. N.Y. 1979)

Jones v. General Tire & Rubbert [sic] *Co.*, 541 F.2d 660 (7th Cir. 1976)

Jones v. Rath Packing Co., 430 U.S. 519 (1977)

Kilgore v. McKethan, 205 F.2d 425 (5th Cir. 1953)

LaCoste v. The Alligator Company, Inc., 506 F.2d 339 (3d Cir. 1974)

Malone v. Gardner, 62 F.2d 15 (4th Cir. 1932)

Martinez v. Southern Ute Tribe, 273 F.2d 731 (10th Cir. 1960)

McCartney v. State of West Virginia, 156 F.2d 739 (4th Cir. 1946)

McCorkle v. First Pennsylvania Banking and Trust Co., 459 F.2d 243 (4th Cir. 1972)

Metropolitan Life Insurance Company v. Massachusetts, 471 U.S. 724 (1985)

Northbrook National Insurance Company v. Brewer, 493 U.S. ___, 107 L. Ed. 2d 223 (1989)

Northeast Nuclear Energy Company v. General Electric Company, 435 F. Supp. 344 (D. Conn. 1977)

Northwest Cent. Pipeline Corp. v. Mesa Petroleum Co., 576 F. Supp. 1495 (D.C. Del. 1983)

People by Atty. Gen. v. Glendale Federal Sav. & Loan Asso., 475 F. Supp. 728 (C.D. Cal. 1979)

Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41 (1987)

Polhemus v. American Medical Ass'n, 145 F.2d 357 (10th Cir. 1944)

Rice v. Exxon Corporation, 631 F. Supp. 1522 (S.D. W.Va. 1986)

Russo v. Kirby, 453 F.2d 548 (2d Cir. 1971)

Screven County v. Brier Creek Hunting & Fishing Club, 202 F.2d 369 (5th Cir. 1953)

Seamon v. Bell Tel. Co., 576 F. Supp. 1458 (W.D. Pa. 1983)

Shamrock Oil & Gas Corp. v. Sheets, 313 U.S. 100 (1941)

Sharp v. AT&T Communications, 660 F. Supp. 650 (N.D. W.Va. 1987)

Shulthis v. McDougal, 225 U.S. 561 (1912)

Swank v. Patterson, 139 F.2d 145 (9th Cir. 1944)

Tafflin v. Levitt, 493 U.S. ___, 107 L. Ed. 2d 887 (1990)

Thomas v. Kroger Co., 583 F. Supp. 1031 (S.D. W.Va. 1984)

Trauss v. City of Philadelphia, 159 F. Supp. 672 (D.C. Pa. 1958)

Warner Bros. Records, Inc. v. R.A. Ridges Distributing Co., 475 F.2d 262 (10th Cir. 1973)

Warrington Sewer Company v. Tracy, 463 F.2d 771 (3d Cir. 1972)

B. *Federal Statutes*

28 U.S.C. § 1332 (attached)

28 U.S.C. § 1441 (attached)

29 U.S.C. § 1001 *et seq.*

29 U.S.C. § 1132 (attached)

29 U.S.C. § 1144 (attached)

42 U.S.C. § 2000 *et seq*

C. *State Statutes*

W. Va. Code, §§ 5-11-1 *et seq*

W. Va. Code, §§ 33-11-1 – 33-11-10

W. Va. Code, §§ 47-18-1 *et seq*

D. *Other*

13 C. Wright A. Miller & E. Cooper, *Federal Practice and Procedure*, § 3566 at 438 (1975)

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF WEST VIRGINIA
(WHEELING DIVISION)

TRI-STATE MACHINE, INC., a West Virginia corporation, Plaintiff, v. NATIONWIDE LIFE INSURANCE COMPANY, an Ohio corporation, Defendant.	CIVIL ACTION NO. ___ (Ohio County Circuit Court Civil Action No. 90-C-131 B)

PLAINTIFF'S MEMORANDUM OF LAW IN SUPPORT OF MOTION TO REMAND

I

STATEMENT OF FACTS

This action was brought in the Circuit Court of Ohio County, West Virginia against defendant for damages arising from a breach of contract by defendant to provide group health insurance for plaintiff's employees under a fixed premium plan. Specifically, it is alleged that defendant breached its duties to administer the benefits program and failed to determine what claims should be paid or what claims should not be paid. It is alleged that defendant failed to timely process claims with the intent of imposing liability on plaintiff under the stop-loss provisions of the plan, and that defendant deliberately mismanaged the contract. It is alleged that defendant breached its fiduciary duty to plaintiff and that defendant breached the implied covenants of good faith and fair dealing. It is also alleged that defendant misrepresented

pertinent facts of the insurance policy and committed the common law and statutory offense of "insurance bad faith." Further, it is alleged that defendant's actions violated the applicable laws of the State of West Virginia, including the rules and regulations of the Insurance Commissioner of the State of West Virginia and, more specifically, Series XV-V-1981, Unfair Trade Practices, relating to deceptive and unfair trade practices.

Defendant filed a notice of removal alleging that this Court has original jurisdiction over plaintiff's civil action pursuant to 29 U.S.C. §1001 *et seq.* (ERISA) and 28 U.S.C. §1332.

However, it is plaintiff's contention that its claim is based entirely and solely upon state law and does not invoke ERISA original jurisdiction.

II

RELEVANT ERISA PROVISIONS

ERISA comprehensively regulates, among other things, employee welfare benefit plans that, through the purchase of insurance or otherwise, provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. 29 U.S.C. §1002(1).

Congress capped off the undertaking of ERISA with three provisions relating to the preemptive effect of the federal legislation as follows:

> Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as

> they may now or hereafter relate to any employee benefit plan. . . . §514(a), as set forth in 29 U.S.C. §1144(a) [29 U.S.C. §1144(a)] (pre-emption clause).
>
> Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. §514(b) (2) (A), as set forth in 29 U.S.C. §1144(b) (2) (A) [29 U.S.C. §1144(b) (2) (A)] (saving clause).
>
> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. §514(b) (2) (B), 29 U.S.C. §1144(b) (2) (B) [29 U.S.C. §1144(b) (2) (B)] (deemer clause).

To summarize the mechanics of the provisions quoted above, if a state law relates to an employee benefit plan, it is preempted. §514(a). The saving clause excepts from the preemption clause those laws that regulate insurance. §514(b) (2) (A). The deemer clause makes it clear that a State law that purports to regulate insurance cannot deem an employee benefit plan to be an insurance company. §514(b) (2) (B). *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 45 (1987).

III

DISCUSSION OF LEGAL ISSUES

A. 28 U.S.C. §1331 and 28 U.S.C. §1441(b) PROHIBIT THIS ACTION FROM BEING REMOVED SINCE PLAINTIFF'S CLAIM IS BASED ON STATE LAW AND DOES NOT INVOKE THE PRINCIPLES OF ORIGINAL JURISDICTION.

A plaintiff is the "master of the complaint." 13 C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure*, §3566 at 438 (1975). He may base his claim solely on state law and defeat a defendant's potential right to remove the cause of action where remedies exist under both state and federal law. *County of Suffolk v. Long Island Lighting Co.*, 549 F. Supp. 1250 (E.D. N.Y. 1982). With that in mind, a complaint states a removable cause of action only if it characterizes a lawsuit as an action for damages under a federal statute and its substantive allegations *clearly* state a federal cause of action. *Seamon v. Bell Tel. Co.*, 576 F. Supp. 1458 (W.D. Pa. 1983). Removal will not be granted on the probability or possibility that a federal question will arise in subsequent proceedings. *Northwest Cent. Pipeline Corp. v. Mesa Petroleum Co.*, 576 F. Supp. 1495 (D.C. Del. 1983). The federal question must be an essential element of a plaintiff's cause of action and a district court is prohibited from looking beyond the complaint to find such a basis for removal. *Jones v. General Tire & Rubber Co.*, 541 F.2d 660 (7th Cir. 1976); *People by Atty. Gen. v. Glendale Federal Sav. & Loan Asso.*, 475 F. Supp. 728 (C.D. Cal. 1979).

The plaintiff herein has based its breach of contract lawsuit on state law with no reference at all to any type of

federal claim. The intent of the plaintiff to pursue its state claim is clear. Plaintiff's civil action is a pure bad faith action seeking remedies within the rules and regulations of the West Virginia Unfair Trade Practices Act, *W. Va. Code*, §§33-11-1 and 33-11-10 (1982). Nevertheless, the defendant urges this Court to disregard the plaintiff's own statement of its claim and recast the issues in a federal light.

It is well-settled in this district that removal statutes are to be strictly construed against removal. *Thomas v. Kroger Co.*, 583 F. Supp. 1031 (S.D. W.Va. 1984); *Continental Resources and Mineral Corp. v. Continental Ins. Co.*, 546 F. Supp. 850 (S.D. W.Va. 1982). Removal of civil cases to a federal court is an infringement on state sovereignty. Accordingly, courts should not extend their jurisdiction beyond the boundaries drawn by the removal statutes. *Shamrock Oil & Gas Corp. v. Sheets*, 313 U.S. 100 (1941). Under the circumstances of this case, the defendant's rephrasing of the issues contravenes the well-established principle that the removal statute is to be strictly construed, and that the exercise of federal jurisdiction is to be rejected in doubtful cases. *Croy v. Buckeye International, Inc.*, 483 F. Supp. 402 (D. Md. 1979); *Irving Trust Co. v. Century Export & Import, S.A.*, 464 F. Supp. 1232 (S.D. N.Y. 1979).

Where a plaintiff's claim involves both a federal ground and a state ground, the plaintiff is free to ignore the federal question and pursue his claim on the state ground, precluding removal based on the existence of a federal question. *Buchannan v. Delaware Valley News*, 571 F. Supp. 863 (E.D. Pa. 1983); *Warner Bros. Records, Inc. v. R. A. Ridges Distributing Co.*, 475 F.2d 262 (10th Cir. 1973);

Brough v. United Steelworkers of America, AFL-CIO, 437 F.2d 748 (1st Cir. 1971); *LaCoste v. The Alligator Company, Inc.*, 506 F.2d 339 (3d Cir. 1974).

Furthermore, the existence of federal jurisdiction on removal must be determined on the face of the plaintiff's complaint. *Gully v. First National Bank*, 299 U.S. 109 (1936). This principle is often referred to a [sic] the "well-pleaded complaint" rule, which provides that federal jurisdiction exists only when a federal question is presented on the face of a properly-pleaded complaint. *Caterpillar, Inc. v. Williams*, 482 U.S. 386 (1987). In *Caterpillar*, the United States Supreme Court held that the well-pleaded complaint rule makes the plaintiff the master of his claim and enables the plaintiff to avoid federal jurisdiction by exclusive reliance on state law. Accordingly, the plaintiff herein has relied on the claims and remedies set forth in the West Virginia Unfair Trade Practices Act and West Virginia contract law, without reference to or reliance on federal law.

Whether removal is proper under 28 U.S.C. §1441(b) hinges on the defendant's assertion that the plaintiff's claim "arises under federal law" under the principles of original jurisdiction pursuant to 28 U.S.C. §1331. However, an examination of Fourth Circuit law and a trilogy of West Virginia district court decisions clearly reveal that plaintiff's case should be remanded to the Circuit Court of Ohio County, West Virginia.

In *Burgess v. Charlottesville Savings & Loan Ass'n*, 477 F.2d 40 (4th Cir. 1973), the Fourth Circuit remanded the plaintiff's claim to state court after ruling that the issues raised in the complaint presented no federal question and

were determinable solely by state law. The plaintiff's action in *Burgess* was one to recover for breach of a contract to procure life insurance. In setting forth such a cause of action in her complaint, the plaintiff included among her allegations the form of notice required by Federal Reserve Regulation Z under the Truth in Lending Act, and based one count of her action on the claim that the failure of the defendant to procure certain life insurance violated Regulation Z of the Truth in Lending Act. The plaintiff's claim in *Burgess* differs from the plaintiff's claim herein in that Burgess based one count on a federal claim where the plaintiff herein has relied entirely on state law with no reference to any federal claims. Because the plaintiff's claim in *Burgess* was made under the Truth in Lending Act, the defendant removed the action to federal court as one "arising under the laws of the United States" under 28 U.S.C. §1441(b).

The District Court for the Western District of Virginia, after finding federal jurisdiction on the ground that the case involved construction and interpretation of federal law, to-wit, the federal Truth in Lending Act, dismissed the action holding there was no evidence that a contract to procure insurance was ever formed. However, the Fourth Circuit disagreed and remanded the cause of action to the state court from which it was removed.

In support of its well-reasoned ruling, the Fourth Circuit placed great emphasis on the principle that cases predicated entirely on the claim that the suit "arises under" federal law are to be resolved on the basis of the allegations of the complaint itself which "affirmatively and distinctly" must establish federal grounds "not in mere form, but in substance," and "not in mere assertion,

but in essence and effect." *Burgess*, 477 F.2d at 43, citing *Barnhart v. Western Maryland Ry. Co.*, 128 F.2d 709, 714 (4th Cir. 1942), and *Cuyahoga Co. v. Northern Ohio Co.*, 252 U.S. 388, 397 (1920). Mere conclusory allegations in the complaint are insufficient to support federal jurisdiction. *Burgess, Id.; Martinez v. Southern Ute Tribe*, 273 F.2d 731 (10th Cir. 1960). As one court expressed it,

> [I]f the concept of federal question is to have any meaning, the court must look beyond the verbiage of a complaint to the substance of the plaintiff's grievance, and dismiss the action, where no real basis for federal jurisdiction exists.[1]

The *Burgess* court fully expanded on the importance of the distinction between claims based upon state law and allegations that such claims "arise under" federal law and reasoned as follows:

> [T]he mere assertion in a pleading that the case is one involving the construction or application of the federal laws does not authorize the district court to entertain the suit nor does federal jurisdiction attach on the bare assertion that a federal right or law has been infringed or violated or that the suit "takes its origin in the laws of the United States." To satisfy the statutory jurisdictional requirement, a federal right must be a "real and substantial" issue in the case and "must be an element of the plaintiff's cause of action. It is often true that, a mere incidental or collateral federal question may appear, or may lurk in the background of the record, but this is

---

[1] *Trauss v. City of Philadelphia*, 159 F. Supp. 672, 676 (D.C. Pa. 1958).

> not a sufficient or adequate basis upon which federal jurisdiction may attach. Simply stated, an action arises under federal law only if it really and substantially involves a dispute or a controversy respecting the validity, construction or effect of such a law, upon which the determination of which the result depends. In ascertaining whether there is a real federal issue upon which the result depends, the courts have observed the distinction between controversies that are basic and those that are collateral, between disputes that are necessary and those that are merely possible, and federal question jurisdiction attaches only to cases where the plaintiff's cause of action, the rule of substance under which he claims the right to have a remedy, is a product of federal law.[2]

The Fourth Circuit in *Burgess* agreed with the plaintiff that the real basis upon which she premised her cause of action was an alleged contract or agreement to procure insurance, the breach of which, under her theory, gave rise to an action both in contract and in tort under the laws of Virginia. Whether the contract was designed to comply with the Truth in Lending Act or not was unimportant according to the Court since the basic issue in the

---

[2] *Burgess, Id.* at 43 and 44, relying upon and citing *Malone v. Gardner,* 62 F.2d 15, 18 (4th Cir. 1932); *McCartney v. State of West Virginia,* 156 F.2d 739 (4th Cir. 1946); *Kilgore v. McKethan,* 205 F.2d 425, 426 (5th Cir. 1953); *Polhemus v. American Medical Ass'n,* 145 F.2d 357 (10th Cir. 1944); *Russo v. Kirby,* 453 F.2d 548 (2d Cir. 1971); *Swank v. Patterson,* 139 F.2d 145 (9th Cir. 1944); *Shulthis v. McDougal,* 225 U.S. 561 (1912); *McCorkle v. First Pennsylvania Banking and Trust Co.,* 459 F.2d 243 (4th Cir. 1972); *Screven County v. Brier Creek Hunting & Fishing Club,* 202 F.2d 369 (5th Cir. 1953); *Warrington Sewer Company v. Tracy,* 463 F.2d 771 (3d Cir. 1972).

case was whether the language used by the defendant in its form of loan application was sufficient to be the basis for the creation of a contractual right which was determinable solely by Virginia law, not federal law. *Burgess, Id.* at 44.

In a trilogy of decisions, the United States District Court for both the Northern and Southern Districts of West Virginia have followed and upheld the ruling in *Burgess.*

In the most recent of the decisions, *Sharp v. AT&T Communications,* 660 F. Supp. 650 (N.D. W.Va. 1987), Judge Kidd remanded the plaintiff's claim against her employer based on insufficient evidence to invoke federal jurisdiction under 28 U.S.C. §1441. In *Sharp,* the plaintiff's complaint alleged two causes of action for breach of contract and the tort of outrageous conduct against the defendant. The defendant removed the claim to federal court pursuant to 28 U.S.C. §1441 alleging that the matter presented federal question jurisdiction based upon a collective bargaining agreement between the parties. However, the district court disagreed and remanded the case to the Circuit Court of Marion County, West Virginia.

The Court in *Sharp* stated the settled rule of law that a federal question must appear on the face of a plaintiff's well-pleaded complaint. *Cook v. Georgetown Steel Corp.,* 770 F.2d 1272 (4th Cir. 1985). The Court further ruled that when a plaintiff presents a state law claim and the defendant counters by arguing that federal law preempts the state law upon which the plaintiff relies, the federal claim appears by way of defense. *Sharp,* 660 F. Supp. at 651, citing *Champion International Corp. v. Brown,* 731 F.2d 1406

(9th Cir. 1984). In that regard, the defense that federal law has preempted the state law upon which the plaintiff relies does not itself create a federal question for purposes of the removal statute. *Sharp, Id.* Although a matter raises substantial issues under both state and federal laws, if a well-pleaded complaint does not invoke federal law, jurisdiction does not exist. *Sharp, Id.*, citing *Georgetown Steel Corp., supra,* at p. 276.

It was apparent to the Court that the plaintiff's claim in *Sharp* was cast in state law and nothing was being sought under the collective bargaining agreement. Thus the case was remanded to circuit court.

In the next decision, Judge Haden, in *Rice v. Exxon Corporation,* 631 F. Supp. 1522 (S.D. W.Va. 1986), remanded a case to the Circuit Courts of Jackson and Kanawha counties on the ground that no federal question was raised by the plaintiff's complaint. In *Rice,* the plaintiff alleged specific counts citing provisions of the West Virginia Antitrust Act, *W. Va. Code,* §§47-18-1 *et seq.*, which the defendant allegedly violated. The defendant alleged that the plaintiff's claim arose under the Constitution or laws of the United States.

However, the district court in *Rice* disagreed and ruled that in determining whether a case arises under the Constitution or laws of the United States, the Court must examine the complaint itself to determine whether a cause of action under federal law is disclosed. *Rice,* 631 F. Supp. at 1524, citing *Gully v. First National Bank,* 299 U.S. 109 (1936). The Court further stated that where a plaintiff's claim involves both a federal ground and a state ground, the plaintiff is free to ignore the federal question

and to premise his claim on the state ground, precluding removal based upon the existence of a federal question. *Rice, Id.*, citing *Buchannan v. Delaware Valley News*, 571 F. Supp. 868, 871 (E.D. Pa. 1983). Similarly, while the position could be taken that the plaintiff's complaint herein arguably involves a federal claim because it involves group health insurance, the plaintiff is nevertheless free to ignore the federal question and to pursue its claim on state grounds.

In the last of the trilogy of remand cases, Judge Haden again ruled in *Ferrell v. Heck's, Inc.*, 604 F. Supp. 683 (S.D. W.Va. 1985), that the complaint alleged only state law-based causes of action that did not authorize removal to federal court, and thus remanded the case to the Circuit Court of Kanawha County. In *Ferrell*, the plaintiff alleged breach of contract and violations of the West Virginia Human Rights Act, *W. Va. Code*, §§ 5-11-1 *et seq.* The defendant removed the case on the basis that the plaintiff's action was brought pursuant to Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000(e) *et seq.* However, the Court agreed with the plaintiff's assertions that she alleged only state law-based causes of action, namely, breach of contract and violations of *W. Va. Code*, §§ 5-11-1 *et seq.* The Court stated as follows:

> The fact that the plaintiff *could have* pursued her sex discrimination claim via Title VII is irrelevant. The plaintiff is the architect of her own lawsuit and "is entitled to allege only non-federal claims, even though [she] could have relied also on federal law." (emphasis added).

Ferrell, Id. at 684; *Freeman v. Colonial Liquors, Inc.*, 502 F. Supp. 367, 369 (D. Md. 1980).

Other jurisdictions have addressed removal to federal court based on ERISA original jurisdiction. Accordingly, it has been held that a federal court does not have jurisdiction over an employee's claims against an employee benefit plan under 29 U.S.C. §1132, where the employee chooses not to assert his ERISA claims but to rely solely on his state law causes of action. *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980).

It has also been held that a federal court lacks jurisdiction under ERISA over a breach of contract suit involving an employer's severance policy where the complaint can be read so that plaintiffs could concede defendant's full compliance with the Act and still maintain the action, thus making the policy's compliance with ERISA irrelevant to the essential issues of the lawsuit. *Bell v. Amcast Industrial Corp.*, 607 F. Supp. 486 (S.D. Ohio (1985). Furthermore, it has been held that a federal court properly abstained from exercising jurisdiction over a state court action where ERISA preemption was raised as a defense and was not readily apparent, since even if preemption would deprive the state court of jurisdiction it could still determine the validity of the defense. *Fresh International Corp. v. Agricultural Labor Relations Bd.*, 805 F.2d 1353 (1986).

The plaintiff's claim herein does not involve a claim for benefits which were denied. The lawsuit addresses various theories of liability, including breach of contract, breach of the implied covenant of good faith and fair dealing, statutory bad faith and violations of West Virginia insurance rules and regulations. Thus, the lawsuit is

predicated upon West Virginia state law which does not invoke the principles of original jurisdiction.

B. 29 U.S.C. §1132(e) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE THE CIRCUIT COURT OF OHIO COUNTY, WEST VIRGINIA HAS CONCURRENT JURISDICTION OVER PLAINTIFF'S CLAIM.

Even assuming *arguendo* that removal is not prohibited by virtue of the lack of original jurisdiction, removal is prohibited by 29 U.S.C. §1132(e) since the Circuit Court of Ohio County, West Virginia has concurrent jurisdiction over plaintiff's claim. In this regard, the Court of Appeals for the First Appellate District of California ruled in *Hughes v. Blue Cross of Northern California*, 263 Cal. Rptr. 850, 215 Cal. App. 3d 832 (1989), that an action against a group health insurer alleging a breach of the covenant of good faith and fair dealing in connection with the denial of coverage for psychiatric hospitalization fell within the concurrent jurisdiction of federal and state courts under ERISA as an action to recover benefits and to enforce rights under the terms of the plan. The Court in *Hughes* ruled that the state court had jurisdiction over the claims made by the plaintiff under 29 U.S.C. §1132(e)(1) which provides:

> (e) Jurisdiction. (1) Except for actions under subsection (a) (1) (B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary. State courts of competent jurisdiction and district courts of the United States shall

> have *concurrent jurisdiction* of actions under subsection (a)(1)(B) of this section. (Emphasis added).

Accordingly, 29 U.S.C. §1132(a)(1)(B) provides:

> (a) Persons empowered to bring a civil action. A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

The *Hughes* court went on to further state that the exception to subsection (a)(1)(B) is a broad one. Thus, if this Court determines that the allegations made by the plaintiff invoke ERISA jurisdiction, the action should clearly be characterized as either one to enforce rights under the terms of the plan, or to clarify rights under the terms of the plan. Therefore, this action should be remanded to the Circuit Court of Ohio County, West Virginia since that court is a state court of competent jurisdiction as those terms are referred to in 29 U.S.C. §1132(e).[3]

---

[3] Also upholding the principles of concurrent jurisdiction was the Court's ruling in *Tafflin v. Levitt*, 493 U.S. ___, 107 L. Ed. 2d 887 (1990). In *Tafflin*, the Court ruled that state courts have concurrent jurisdiction to hear civil claims arising under RICO, since RICO rules and regulations borrow heavily from state law.

C. 29 U.S.C. §1144(b)(2) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE PLAINTIFF'S CLAIM IS BASED UPON STATE LAW "WHICH REGULATES INSURANCE."

The plaintiff's lawsuit alleges violations of the West Virginia Unfair Trade Practice Act, and such lawsuits are commonly referred to as "bad faith" actions. As such, the plaintiff is relying on the regulations set forth in *W. Va. Code*, §§33-11-1 and 33-11-10, for its remedies. This statutory authority regulates the insurance industry throughout the State of West Virginia and outlines the specific violations within which an aggrieved party may rely. Because this statute is one which regulates insurance, the saving clause prevents the state law from being preempted.

The Supreme Court has ruled that a common-sense view of the word "regulates" leads to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 50 (1987). Thus, the roots of the West Virginia laws of "bad faith" with the insurance industry are firmly planted in general principles of West Virginia insurance regulatory law.

The United States Supreme Court addressed this specific issue in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985). Metropolitan Life addressed certain exceptions to the preemption doctrine involving ERISA claims. The court ruled that a Massachusetts statute requiring that specific minimum mental health-care benefits be provided in insurance policies was

not preempted by ERISA. The attorney general of Massachusetts brought suit in Massachusetts for declaratory and injunctive relief against out-of-state insurers to force them to comply with a Massachusetts statute which required minimum mental health care benefits to Massachusetts residents insured under a general insurance policy, an accident or sickness insurance policy, or an employee health care plan that covered hospital and surgical expenses. The insurers contended that the state statute was preempted by ERISA, and that the statute, as applied to insurance policies purchased pursuant to a negotiated collective-bargaining agreement, was preempted by the National Labor Relations Act (NLRA).

The Superior Court of Massachusetts issued a permanent injunction requiring the insurers to provide the coverage mandated by the state statute, and the Supreme Judicial Court of Massachusetts affirmed, finding no preemption under either ERISA or the NLRA. The United States Supreme Court affirmed in a unanimous opinion and ruled that while the state statute related to pension plans governed by ERISA so as to fall within the broad preemption provision of ERISA (29 U.S.C. §1144(a)), the state statute was saved by preemption by 29 U.S.C. §1144(b)(2) as a law "which regulates insurance."

The Court held that plans that purchase insurance, so-called "insurance plans," are directly affected by state laws that regulate the insurance industry. *Metropolitan Life, Id.* at 732. Furthermore, since nothing in ERISA regulates the content of welfare plans, the Court ruled that State regulation of insurance that indirectly affects the contents of welfare plans is *not* preempted by ERISA. *Id.* at 736.

After discussing the presumption that Congress did not intend to preempt areas of traditional state regulations as stated in *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977), the Court in *Metropolitan Life* discussed the saving clause as it related to the deemer clause, and ruled:

> This common-sense view of the matter, moreover, is reinforced by the language of the subsequent subsection of ERISA, the "deemer clause," which states that an employee-benefit plan shall not be deemed to be an insurance company "for purposes of any law of any State purporting to regulate insurance companies, *insurance contracts*, banks, trust companies, or investment companies. §514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B) [29 U.S.C. §1144(b)(2)(B)] (emphasis added). By exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance savings clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.

Metropolitan Life, Id. at 741.

Accordingly, if this Court finds that the plaintiff's claims invoke original jurisdiction under ERISA, the claims must surely fall under a state law "which regulates insurance" which would then be saved from preemption by virtue of the saving clause. Also, the group health

insurance contract in dispute should be considered an "insurance contract" saved from preemption by virtue of the deemer clause. Therefore, plaintiff's claim should be remanded to the Circuit Court of Ohio County, West Virginia.

D. 28 U.S.C. §1322(c) PROHIBITS THIS ACTION FROM BEING REMOVED SINCE DIVERSITY OF CITIZENSHIP DOES NOT EXIST.

The defendant carries the burden of proof to demonstrate its diversity of citizenship. *Northeast Nuclear Energy Company v. General Electric Company,* 435 F. Supp. 344 (D. Conn. 1977). In that regard, the United States Supreme Court in *Northbrook National Insurance Company v. Brewer,* 493 U.S. ___, 107 L. Ed. 2d 222 (1989), ruled that for diversity purposes, an insurer is a citizen of the same state as the insured in a direct action against a liability insurer. The plaintiff herein is a resident of the State of West Virginia. As such, in its direct action against the defendant, Nationwide Life Insurance Company, the defendant is considered a resident of the State of West Virginia for purposes of this lawsuit based upon the ruling set forth in *Northbrook.*

In *Northbrook,* the diversity of citizenship proviso under 28 U.S.C. §1332(c) was held not to apply to a workers' compensation action brought by the insurer. The plaintiff had filed a workers' compensation claim against Northbrook after he allegedly suffered an injury during the course of his employment, and the Texas Industrial Accident Board processed his claim and awarded him

compensation. The Texas workers' compensation law permitted any party dissatisfied with a Board ruling to file a civil suit to set the decision aside. As a result, *Northbrook* filed suit against *Brewer* in federal district court invoking the court's diversity jurisdiction under 28 U.S.C. §1332. The district court dismissed for lack of subject-matter jurisdiction on precedent that required it to apply the direct action proviso of the diversity statute. That proviso states:

> In any direct action against the insurer of a policy or contract of liability insurance, whether incorporated or unincorporated, to which action the insured is not joined as a party-defendant, the insurer shall be deemed a citizen of the State of which the insured is a citizen, as well as of any State by which the insurer has been incorporated and of the State where it has its principal place of business.

28 U.S.C. §1332(c).

The district court in *Northbrook* attributed the plaintiff's employer's Texas citizenship to Northbrook, eliminating diversity between Northbrook and the plaintiff. The Court of Appeals affirmed, but the United States Supreme Court reversed holding that the direct action proviso was not applicable because Northbrook's suit was an action *by*, not against, an insurer.

However, the plaintiff's claim herein is a direct action *against* an insurer. As such, the direct action proviso applies, and the defendant should be considered a resident of the State of West Virginia for diversity purposes. Accordingly, diversity of citizenship does not exist between the plaintiff and the defendant.

Also, in *Hudler v. Wilson*, 376 F. Supp. (D. Colo. 1974), multiple defendants attempted to remove a state court action to the district court in Colorado. The district court held that such an action on the basis of diversity was not removable because one of the parties who had been properly joined was a resident of Colorado, and therefore, removal was prohibited under 28 U.S.C. §1441(b).

The plaintiff requests that the same reasoning be applied to its claim to remand this civil action to the Circuit Court of Ohio County, West Virginia.

IV

CONCLUSION

For all the reasons set forth herein, plaintiff requests that this action be remanded to the Circuit Court of Ohio County, West Virginia, and that the Court assess costs and fees, and make a determination of whether or not the notice of removal was filed in good faith.

TRI-STATE MACHINE, Plaintiff

By /s/ Ray A. Byrd
Of Counsel

CERTIFICATE OF SERVICE

Service of the foregoing Plaintiff's Memorandum of Law in Support of Motion to Remand was had upon the defendant by mailing a true copy thereof, by United States mail, postage prepaid, to its counsel of record, on this 23rd day of April, 1990, as follows:

Eliott R. Good, Esq.
Joseph J. Golian, Esq.
CHORPENNING, GOOD & MANCUSO CO., LPA
492 S. Third Street
Columbus, OH 43215
Counsel for Defendant

/s/ Ray A. Byrd
Of Counsel

Ray A. Byrd, Esq.
Gregory A. Gellner, Esq.
SCHRADER, STAMP, BYRD, BYRUM & COMPANION
1000 Hawley Building
Wheeling, WV 26003
(304) 233-3390